MATERNAL SUPPORT SERVICES PLAN OF CARE

Beneficiary Name	Date of Birth	E.D.C	Gravida	Para	Medical Care Provider

Care Coordinator	Discipline

PROBLEMS/ NEEDS	GOALS/ OBJECTIVES	INTERVENTIONS
Health		
Family Planning	Assist beneficiary/family to achieve their goal of spacing and composition of family through use of birth control method of her choice.	
Smoking ☐ Beneficiary Amount _____ ☐ Quit Smoking When _____ ☐ Environmental Smoke Who _____ ☐ Smoke-Free Environment	Beneficiary will have a smoke-free environment.	
Immunization Status for Mother (Based on Immunization Record/MCP) ☐ Up To Date ☐ Not Up To Date Status of Preschool Child(ren) (Based on MICR/Immunization Record/MCP) ☐ Up To Date ☐ Not Up To Date	Beneficiary will remain current with immunizations.	
Nutrition		

Beneficiary's Name: _____

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PROBLEMS/ NEEDS	GOALS/ OBJECTIVES	INTERVENTIONS
Emotional/ Mental Health		
Alcohol/ Drug Use		
Environmental		
Childbirth Education Class	Beneficiary will receive the benefits of a group setting.	
Transportation	Beneficiary will not miss any appointments due to a lack of transportation.	
Other		

We the undersigned have reviewed the initial assessment and have participated in the above described plan. We concur with the number of visits to implement the interventions.
Estimated Number of Visits By: _____RN _____SW _____RD

RN Signature	Date	SW Signature	Date	RD Signature	Date

Care Plan Update

We the undersigned have reviewed the care plan update and agreed to the changes in the above described plan. We concur with the number of visits to achieve the specific objectives.
Estimated Number of Visits By: _____RN _____SW _____RD

RN Signature	Date	SW Signature	Date	RD Signature	Date